4 Months Old — AHCCCS EPSDT Tracking Form

Date	Last Name	First Name	AHCCCS ID #	DOB	Age

Primary Care Provider	PCP ph. #	Health Plan	Accompanied by (name)	Relationship

NICU: ☐ yes ☐ no	PEDS : ☐ yes ☐ no	PEDS Pathway:	Birth Wt:	Allergies:	Temp:	Pulse:	Resp:

Risk indicators of hearing loss: ☐ yes ☐ no	Medications:	Wt:	%	Length:	%	Head circ:	%

PARENTAL CONCERNS/HISTORY:

NUTRITIONAL SCREEN: [X] INDICATES GUIDANCE GIVEN: ☐ Breast fed ☐ Formula: _____
☐ Cereal ☐ Plan to introduce solids_____
☐ Soda/Juice ☐ Adequate intake ☐ Supplements:

DEVELOPMENTAL SCREEN: [X] INDICATES ACCOMPLISHMENTS ☐ Babbles and coos ☐ ☐ Smiles ☐ Begins to roll front to back ☐ Pushes up with arms ☐ Controls head well ☐ Reaches for objects ☐ Interest in mirror images ☐ Pushes down with legs when feet on surface ☐ Looks at you with eyes ☐ Other

AGE APPROPRIATE EDUCATION AND GUIDANCE: [X] INDICATES GUIDANCE GIVEN: ☐ Car seat/rear facing ☐ Emergency 911 ☐ Bottle prop ☐ Support/who can help? ☐ Infant crying/what to do? ☐ Safe bathing/water temperature ☐ Shaken baby prevention ☐ Establish daily routines/infant regulation ☐ Establish nighttime sleep routine/sleep through night=5 hours ☐ Introduce child temperament/easy/sensitive ☐ Passive smoke ☐ Parent reads to child ☐ Other

BEHAVIORAL HEALTH SCREEN: [X] INDICATES OBSERVED BY CLINICIAN/PARENT REPORT: ☐ Family Adjustment/Parent responds positively to baby ☐ Length of time infant cries ☐ Infant hands to mouth/self calming ☐ Smiles when hears parents' voice ☐ Encourage holding ☐ Easily distracted/excitement of discovery of outside world ☐ Other

COMPREHENSIVE PHYSICAL EXAM:

	WNL	Abnormal (see notes below)		WNL	Abnormal (see notes below)
Skin/Hair/Nails			Lungs		
Eyes/Vision			Abdomen		
Ear			Genitourinary		
Mouth/Throat/Teeth			Extremities		
Nose/Head/Neck			Spine		
Heart			Neurological		

ASSESSMENT/PLAN/FOLLOW UP

LABS ORDERED: [X] INDICATES ORDERED ☐

IMMUNIZATIONS: [X] INDICATES ORDERED ☐ Pt. Needs immunization today ☐ Delayed/Deferred ☐ Parent refuses ☐ Other reason ☐ Hepatitis B ☐ DTaP ☐ Hib ☐ IPV ☐ PCV ☐ Rotavirus ☐ Other

REFERRALS: [X] INDICATES REFERRED ☐ CRS ☐ WIC ☐ ALTCS ☐ PT ☐ OT ☐ Audiology ☐ Speech ☐ AzEIP/ DDD ☐ Developmental ☐ Early Head Start ☐ Behavioral ☐ Specialty ☐ Other

_____ See Additional Supervisory note ☐**Yes** ☐**No**

Date/Time Clinician name (print) Clinician Signature

Revised November 1, 2007